

INTRODUCING YOUR EMPLOYEE GROUP INSURANCE PROGRAM

The State of Idaho is pleased to provide a comprehensive group insurance program to eligible employees. The program offers employees a variety of benefits including:

- **Blue Cross of Idaho Traditional, PPO and High Deductible Medical Plans:** These plans provide hospital, physician, prescription drug and vision benefits. EAP benefits are included in each medical plan, with claims management provided by ComPsych.
- **thriveidaho:** Health promotion program available to all employees enrolled in one of the state's medical plans. Visit the [thriveidaho](https://thriveidaho.com) website to find out how to get started earning rewards.
- **Blue Cross Dental Plan:** Covered under this plan are routine and preventive care, basic services, major services and orthodontia.
- **Life Insurance:** The Basic Life plan is provided by the State at no cost to employees. Also available is an employee-paid optional Voluntary Term Life plan and a State Police Optional Life policy for all eligible police officer members of the Idaho State Police.
- **Disability Insurance:** Short-term Disability and Long-term Disability insurance coverages automatically provided to all eligible employees as part of the Basic Life plan.
- **Flexible Spending Accounts:** The Medical Reimbursement and Dependent Care Reimbursement Accounts allow employees an opportunity to set aside tax exempt funds to pay out-of-pocket health and dependent care expenses.
- **Premium Only Plan:** Lets employees save money by having medical and dental premiums deducted from their pay on a pre-tax basis.

This is a summary of the State of Idaho employee group insurance plans and does *not* include all the details about plan provisions, exclusions or limitations. **To get the details, be sure to refer to the individual plan [contracts](#).**

All plans are administered by the Director of the Department of Administration. The Director is empowered to amend or terminate these plans or any benefits provided by these plans at any time. Participants will be notified as to any such changes as required by governing regulations. Neither this summary nor any of the State's policies for benefit plans should be considered a contract for purposes of employment or payment of compensation or benefits.

The Director exercises the ultimate discretionary authority and control over the plan and the management and disposition of plan assets. Benefit payments are subject to the provisions of each plan contract. The costs associated with this publication are available from the Department of Administration, Office of Group Insurance in accordance with Section 60-202, Idaho Code – 01/97/2, 500/5301-0461.

THE OFFICE OF GROUP INSURANCE

The Office of Group Insurance, Department of Administration as established in Idaho Code 67, Chapter 57, sponsors and administers all group medical, dental, life, accidental death and dismemberment, disability, and Flexible Spending Account insurance contracts and policies for the employees of the State of Idaho and their dependents. To ask questions or obtain information about these plans contact the Office of Group Insurance at:

Street Address: 304 N 8th Room 434, Boise, ID
Mailing Address: P.O. Box 83720
Boise, ID 83720-0035
Phone Number: 208-332-1860 (Local)
1-800-531-0597 (Toll-Free Long Distance)
TDD Voice Relay: 1-800-377-1363
TDD Service with Text: 1-800-377-3529
Email: ogi@adm.idaho.gov

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ABOUT THE PLANS

Here is a brief summary of general provisions of the State of Idaho's employee group insurance plans. **Remember, for more details refer to the individual plan [contracts](#).**

ELIGIBLE EMPLOYEES

Eligible Employees are officers or employees of state agencies, departments, or institutions, including state officials, elected officials, or employees of other governmental entities which have contracted with the State of Idaho for medical expense coverage, who are working twenty (20) hours or more per week and whose term of employment is expected to exceed five (5) consecutive months. Employees receive coverage only when they meet the eligibility requirements. There are certain limitations as to employment classifications, which can be found in the individual plan documents or contracts in this summary.

ELIGIBLE DEPENDENTS

Eligible Dependents include (1) spouses and (2) children up to their 26th birthdays. The term "children" includes natural children, stepchildren, adopted children, or children in the process of adoption from time of placement. The term "children" also includes children legally dependent upon an employee or his/her spouse for support where a normal parent-child relationship exists with the expectation that the employee will continue to rear that child to adulthood; however, if one or both of that child's natural parents live in the same household with the employee, a parent-child relationship shall not be deemed to exist even though the employee provides support.

NO DUAL COVERAGE

No one may be simultaneously insured under any of the State plans as a member of more than one insurance class, as an insured employee and an insured dependent or as more than one insured individual or insured dependent.

ELECTING COVERAGE

Employees must submit applicable enrollment documents before coverage begins. Employees can obtain enrollment information and instructions from their Human Resources offices. Employees whose agencies are on the State Controller's Payroll system must submit medical, dental, POP and FSA electronically via the Employee Self Service program and via hardcopy forms for life insurance. Employees whose agencies maintain their own payroll systems must complete hardcopy forms for all coverages.

Once employees have enrolled in a medical plan they may not change to another plan until the next Open Enrollment period.

Plan	When Coverage Begins
Medical	<ul style="list-style-type: none">• If enrollment occurs within 30 days of employee's hire date, the first day of the month following date of hire. After 30 days, the first day of the month following date of application.• If enrollment occurs within 60 days of marriage, coverage for a new spouse and/or stepchildren is effective the first day of the month following date of marriage. After 60 days, the first day of the month following date of application.• Newborns and newborn adoptive children have coverage effective on date of birth, provided application is made within 60 days of birth. After 60 days, the first day of the month following date of application.• For adoptive children older than 60 days, coverage is effective on date of placement with the employee provided application is submitted within 60 days of placement. After 60 days of placement, the first day of the month following date of application.
Dental	When medical coverage begins. If employees decline dependent dental coverage, they must wait until the following Open Enrollment period to elect it again.
Basic Life Insurance	The first day of the month following date of hire; no enrollment required.

Plan	When Coverage Begins
Voluntary Term Life Insurance	<p>If enrollment occurs:</p> <ul style="list-style-type: none"> • Within 30 days of hire date, the first day of the month following date of hire. After 30, days without a qualifying event, evidence of insurability (good health) will be required. • Within 31 days of a qualifying event (marriage, divorce, birth, adoption, job change), the first day of the month following the event.
State Police Optional Life Insurance	<p>If enrollment occurs within 30 days of hire, the first day of the month following date of hire. After 30 days of hire, evidence of insurability (good health) will be required.</p>
Disability Coverage	<p>The day Basic Life coverage becomes effective; no enrollment required.</p>
Flexible Spending Accounts	<p>For the Medical Reimbursement Account, if enrollment occurs:</p> <ul style="list-style-type: none"> • Within 30 days of hire date, the first day of the month following date of hire. Employees who do not enroll during the initial 30 day eligibility period must wait until the following Open Enrollment period. <p>For the Dependent Care Account, if enrollment occurs:</p> <ul style="list-style-type: none"> • Within 30 days of hire date, the first day of the month following date of hire. Employees who do not enroll during the initial 30 day eligibility period must wait until the following Open Enrollment period unless they experience a qualifying event. • Within 31 days of a qualifying event, the first day of the month following date of application.
Premium Only Plan (medical/dental premiums withheld on a pre-tax basis).	<p>If enrollment occurs:</p> <ul style="list-style-type: none"> • Within 30 days of hire date, the first day of the month following date of hire. Employees who do not elect to participate during the initial 30 day eligibility period must wait until the following Open Enrollment period unless they experience a qualifying event. • Within 30 days of a qualifying event, the first day of the month following date of application.

WAITING PERIODS

Medical Plans

There are no waiting periods in any of the State's employee medical plans.

Dental Plan

For all new dental plan enrollees, there is a twelve (12) month waiting period for major care and orthodontia services. Please refer to the Blue Cross Dental Plan [contract](#) for specific details.

A member's time enrolled in a prior dental plan cannot be credited against the waiting period in the State's dental plan.

WHEN COVERAGE ENDS

Coverage under the various Group Insurance plans ends on the earliest of these dates:

- When State employment terminates. If active status ends:
 - *Before the 15th of a month*, coverage will continue through the end of that month.
 - *On or after the 15th of a month*, coverage will continue through the end of the following month.
- When an employee ceases to be eligible.
- When the plan is terminated.
- For enrolled dependents, coverage ends when an employee's coverage ends or the end of the month in which they cease to be eligible — whichever comes first.

BENEFITS WHILE ON A LEAVE OF ABSENCE

Leave Without Pay (LWOP)

Employees may continue medical, dental, Basic Life, Voluntary Term Life and/or State Police Optional Life coverages for up to six (6) months (twelve [12] months if on an employer-sponsored leave for professional or educational purposes), by self-paying the full monthly premium, including any amount the State usually pays for active employees.

Disability insurance is *not* available for continuation during LWOP — coverage ends after thirty (30) days, counted from the first day after the leave starts.

Family Medical Leave Act (FMLA)

- **Medical and Dental:** The State will continue to pay its share of the premiums, the same as for active employees, while employees continue to pay their shares during approved FMLA leave. Following FMLA leave, employees can continue coverage by self-paying the full cost for the balance of six (6) months following initial date of leave.
- **Basic Life:** During the FMLA period, the State will pay the monthly premiums. After that, employees can continue coverage by self-paying the full cost for a maximum of six (6) months from initial date of leave.
- **Voluntary Term Life and Police Optional Life:** For up to six (6) months from the date leave begins, by self-paying the full premiums.

Disability

When an employee files a disability claim, the Office of Group Insurance sends him/her a detailed explanation of options for continuing coverage, including required premium contributions. In general, employees may continue coverage as follows:

- **Medical and Dental:** For up to thirty (30) months from date of disability or until the disability claim closes, **whichever occurs first**.
- **Basic Life and Voluntary Term Life:** Basic Life will continue at no cost to the employee. Employees must pay Voluntary Term Life premiums for the first six (6) months following date of disability.
- **State Police Optional Life:** Employees must pay the premiums for the first six (6) months following date of disability.

COBRA

After eligibility for group coverage ends, employees and/or dependents may be able to elect a COBRA continuation of medical and dental coverages. Employees enrolled in the FSA may be eligible to continue their Medical Reimbursement Account participation, but only on a post-tax contribution basis.

COBRA Qualifying Events

Qualifying Event	Individuals Eligible for COBRA	Duration of COBRA Coverage
Employee's termination of employment or reduction of work hours	Employee, Spouse, Dependent child	Up to 18 months from the date Active plan coverage ends
Employee's death Divorce or legal separation	Spouse, Dependent child	Up to 36 months from the date Active plan coverage ends
Loss of dependent child status	Dependent child	Up to 36 months from the date Active plan coverage ends

COBRA Extensions

The eighteen (18) month COBRA period may be extended up to twenty-nine (29) months in the event an individual is disabled according to the Social Security Administration. Additional information about the twenty-nine (29) month COBRA period is available from the Office of Group Insurance.

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If another qualifying event takes place during the eighteen (18) month continuation period that would entitle a dependent to a longer period of continued coverage, the COBRA period may be extended. At the most, however, coverage cannot be extended past thirty-six (36) months from the date active plan coverage terminated.

COBRA Election

To continue coverage, the insured person must elect coverage within sixty (60) days after group coverage terminates. To request additional information contact the Office of Group Insurance.

Termination of COBRA

COBRA coverage will end on the earliest of the following dates:

- At the end of the applicable coverage continuation period;
- The date the required contributions are no longer made;
- The date the COBRA participant becomes entitled to Medicare;
- The date the COBRA participant becomes covered by any other group health plan; or
- The date the State terminates health care coverage for all employees.

LIFE INSURANCE CONVERSION OPTIONS

When eligibility for group life insurance coverage ends, employees can apply for a conversion to an individual policy offered by Principal Life Insurance Company — no evidence of insurability is required if application is made within thirty-one (31) days after group coverage ends. Conversion policies are not available for disability coverages.

Costs, provisions and benefits of conversion policies may differ substantially from those of the group plans. Additional information and conversion applications are available from the Office of Group Insurance.

RETIREE MEDICAL COVERAGE

The state offers eligible retirees the choice of Blue Cross of Idaho PPO, Traditional and High Deductible medical plans. To be eligible a retiree must:

- have been hired on or before June 30, 2009
- be under age 65
- have at least 20,800 hours of credited state service
- be receiving monthly retirement benefits from a State Retirement System
- and retire directly from state service.

Retirees hired after June 30, 2009 are not eligible for coverage unless they have credited state service of at least 20,800 hours before June 30, 2009 and subsequent to reemployment, election or reappointment on or after July 1, 2009 accumulate an additional 6,240 continuous hours of credited state service and are otherwise eligible for coverage.

You can find more information regarding the state's retiree medical plans, including dependent eligibility requirements, online at ogi.idaho.gov/retirees/

FISCAL YEAR 2015 PREMIUMS

MEDICAL AND DENTAL COVERAGES

Bimonthly Premium Rates

For employees whose agencies are on a biweekly payroll system, half the monthly premium is deducted on the first payday of the month and the other half on the second payday of each month to pay for the following month's coverage.

Full-Time Tier

(employees working 30 to 40 hours per week)

Employer Medical Contribution: 429.99 \$ Employer Dental Contribution: \$ 9.59

	Employee Only	Employee & Spouse	Employee & Child	Employee & Children	Employee, Spouse & Child	Employee, Spouse & Children
PPO Plan	\$23.50	\$59.50	\$41.00	\$55.00	\$74.50	\$ 85.50
Traditional Plan	\$29.00	\$72.00	\$51.00	\$66.50	\$90.50	\$101.00
High Deductible Plan	\$19.00	\$50.50	\$34.00	\$46.00	\$63.00	\$ 70.50
Dental	\$ 4.12	\$19.12	\$16.12	\$24.62	\$27.37	\$ 31.62

Part-Time Tier

(employees working 20 – 29.9 hours per week)

Employer Medical Contribution: \$348.29 Employer Dental Contribution: \$ 7.67

	Employee Only	Employee & Spouse	Employee & Child	Employee & Children	Employee, Spouse & Child	Employee, Spouse & Children
PPO Plan	\$105.20	\$141.20	\$122.70	\$136.70	\$156.20	\$167.20
Traditional Plan	\$110.70	\$153.70	\$132.70	\$148.20	\$172.20	\$182.70
High Deductible Plan	\$100.70	\$132.20	\$115.70	\$127.70	\$144.70	\$152.20
Dental	\$ 6.04	\$ 21.04	\$ 18.04	\$ 26.54	\$ 29.29	\$ 33.54

Monthly Premium Rates

For employees of agencies on a monthly payroll system, premiums are deducted in full from each paycheck to pay for that month's coverage.

Full-Time Tier

(employees working 30 to 40 hours per week)

Employer Medical Contribution: \$859.98 Employer Dental Contribution: \$19.18

	Employee Only	Employee & Spouse	Employee & Child	Employee & Children	Employee, Spouse & Child	Employee, Spouse & Children
PPO Plan	\$47.00	\$119.00	\$ 82.00	\$110.00	\$149.00	\$171.00
Traditional Plan	\$58.00	\$144.00	\$102.00	\$133.00	\$181.00	\$202.00
High Deductible Plan	\$38.00	\$101.00	\$ 68.00	\$ 92.00	\$126.00	\$141.00
Dental	\$ 8.24	\$ 38.24	\$ 32.24	\$ 49.24	\$ 54.74	\$ 63.24

Part-Time Tier
(employees working 20 – 29.9 hours per week)
Employer Medical Contribution: \$696.58 Employer Dental Contribution: \$15.34

	Employee Only	Employee & Spouse	Employee & Child	Employee & Children	Employee, Spouse & Child	Employee, Spouse & Children
PPO Plan	\$210.40	\$282.40	\$245.40	\$273.40	\$312.40	\$334.40
Traditional Plan	\$221.40	\$307.40	\$265.40	\$296.40	\$344.40	\$365.40
High Deductible Plan	\$201.40	\$264.40	\$231.40	\$255.40	\$289.40	\$304.40
Dental	\$ 12.08	\$ 42.08	\$ 36.08	\$ 53.08	\$ 58.58	\$ 67.08

PREMIUM ONLY PLAN (POP)

The Premium Only Plan allows employees to have medical and dental premiums deducted from their paychecks on a pre-tax basis (before Federal or state taxes are withheld). After initial enrollment, a POP election can *only* be changed when a qualifying event occurs or during the annual open enrollment period.

BASIC LIFE

The State pays the premium for this coverage — there is no cost to employees.

DISABILITY COVERAGES

The State pays the full premium for Short-Term Disability and Long-Term Disability coverages. Since the premiums for this coverage are employer-paid, claimants may have to pay income and FICA (Medicare/Social Security) taxes on some or all of the benefits they receive.

VOLUNTARY TERM LIFE INSURANCE

Employees pay the entire premium for this coverage. How much depends on the benefit amount and the employee's age group. Following are rates for Fiscal Year 2015.

Employee Age	Employee Coverage Monthly Rates Per \$1,000 Coverage	Spouse Coverage Monthly Rates Per \$10,000 of Coverage
35 and under	.08	\$0.80
36-40	.12	\$1.20
41-45	.17	\$1.70
46-50	.27	\$2.70
51-55	.43	\$4.30
56-60	.77	\$7.70
61-65	1.04	\$10.40
66-70	1.59	\$15.90
71-75	2.27	\$22.70
76-80	3.43	\$34.30
81-85	5.11	\$51.10

Child Coverage	Monthly Premium Per Family
\$10,000	\$2.00

STATE POLICE OPTIONAL LIFE

Employees pay half of the \$6.78 monthly premium and the State pays the other half.

8 Summary of Benefits

MEDICAL PLANS

Eligible employees can enroll themselves and their eligible dependents for medical coverage and have the choice of a Blue Cross of Idaho PPO, Traditional or High Deductible plan. For details about the plans, please refer to the [contracts](#). To locate participating providers, please refer to the Blue Cross of Idaho [Provider directory](#).

HOW THRIVEIDAHO WORKS

thriveidaho is an employee health promotion program designed to reward and promote healthy lifestyles through a variety of programs and resources for state of Idaho employees. The program is available to all employees enrolled in one of the state's Blue Cross of Idaho medical plans as the subscriber. Learn how to start earning rewards at thrive.idaho.gov.

BLUE CROSS PPO PLAN

The following benefits outline is an easy reference document that contains general payment information. For plan details, including eligible expenses, exclusions and limitations, please refer to the [contract](#). Annual amounts, including deductibles, out-of-pocket amounts and benefit limits, are based on a Benefit Period, which runs from July 1 through June 30.

Plan Features	PPO Plan In-Network	PPO Plan Out-Of-Network
Deductibles: Individual Family	Insured pays first \$250 of eligible expenses per Benefit Period, except for Covered Services that require a Copayment. Insureds pay a combination of \$750 of eligible expenses for all Insureds under same Family Coverage per Benefit Period, except for Covered Services that require a Copayment. <i>(No insured may contribute more than the Individual Deductible amount toward the Family Deductible.)</i>	Insured pays first \$500 of eligible expenses per Benefit Period. Insureds pay a combination of \$1,500 of eligible expenses for all Insureds under same Family Coverage per Benefit Period. <i>(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)</i>
Out-of-Pocket Limit- Coinsurance plus Deductible <ul style="list-style-type: none"> Individual Family Out-of-Pocket expenses associated with the following are not included in the Out-of-Pocket Limit: <ul style="list-style-type: none"> Amounts that exceed the Maximum Allowance. Copayments. Amounts that exceed benefit limits. Dental Covered Services, except Dental Services Related to Accidental Injury. Vision care Covered Services Prescription Drug Covered Services. Noncovered services or supplies. 	Insured pays \$3,250 of eligible expenses per Benefit Period. Insureds pay a combination of \$6,750 of eligible expenses per Benefit Period. When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for dental covered services, vision care, Prescription Drug Covered Services, and amounts exceeding benefit limits. <i>(No Insured may contribute more than the Individual Out-of-Pocket Limit toward the Family Out-of-Pocket Limit.)</i>	Insured pays \$6,500 of eligible expenses per Benefit Period. Insureds pay a combination of \$13,500 of eligible expenses per Benefit Period When the Out-of-Pocket Limit is met, benefits payable for Covered Services increases to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for dental covered services, vision care, Prescription Drug Covered Services, and amounts exceeding benefit limits. <i>(No Insured may contribute more than the Individual Out-of-Pocket Limit toward the Family Out-of-Pocket Limit.)</i>

PPO Plan Prescription Drug Benefits		
	Participating	Non-Participating*
Tier 1: Generic Drugs Tier 2: Formulary Brand Name Drugs Tier 3: Non-Formulary Brand Name Drugs <u>Maintenance Drugs Only</u> One (1) Copayment for <i>each</i> 30-day supply Two (2) Copayments for <i>each</i> 60-day supply Three (3) Copayments for <i>each</i> 90-day supply of Maintenance drugs only (1-30 day supply, 1 Copayment; 31-60 day supply, 2 Copayments, 61-90 day supply, 3 Copayments) <u>Nonmaintenance Drugs</u> Limited to a 30-day supply at one time Note: Certain prescription drugs have Generic equivalents. If the Insured or Provider requests a Brand Name Drug and a Generic Drug is available, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug plus any applicable Copayment.	Insured pays \$10 per prescription. Insured pays \$25 per prescription. Insured pays \$50 per prescription.	Insured pays \$10 per prescription. Insured pays \$25 per prescription. Insured pays \$50 per prescription. * For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Insured is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment and/or Coinsurance from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.
Diabetes Management Insulin Syringes/Needles Insulin syringes/needles covered if purchased within 30 days of Insulin purchase. (only 1 copayment required) Other Diabetic Supplies Benefits shall be provided for blood sugar diagnostics: <ul style="list-style-type: none"> • lancets • test strips (blood glucose and urine) • alcohol swabs 	Insulin subject to above listed pharmacy copayments. Insured pays \$10 per item.	Insulin subject to above listed pharmacy copayments. Insured pays \$10 per item.
Prescribed Contraceptives	BCI pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI web site, www.bcidaho.com ; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	
Human Growth Hormone Therapy (Prior Authorization required).	Subject to above listed pharmacy copayments	Subject to above listed pharmacy copayments

PPO Plan Vision Care Benefits	
Plan Features	VSP Pays Up to the Amounts Listed
Professional Fees Eye Exam	\$50
Materials – Lenses Per Pair Single Vision, up to Bifocal, up to Trifocal, up to Lenticular, up to Frame, up to	\$50 \$80 \$95 \$125 \$50
Contact Lenses – Per Pair Elective, up to Medically Necessary, up to	 \$70 \$125
Service Frequency Limitations	Insured may receive one (1) eye exam every twelve (12) months. Insured may receive one (1) pair spectacle lenses or contact lenses every twelve (12) months. Insured may receive one (1) frame every twenty-four (24) months.
Value Added Discounts from a VSP Participating Doctor	<p>The following discounts apply when visiting a VSP Participating Doctor:</p> <ul style="list-style-type: none"> • 20% savings on lens options like progressives and scratch resistant coatings when a complete pair of glasses is received. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 20% off additional pairs of glasses and non-prescription sunglasses, including non-covered lens options. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 15% off cost of contact lens exam (evaluation and fitting); materials not included. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor.

BLUE CROSS TRADITIONAL PLAN

The following benefits outline is an easy reference document that contains general payment information. For plan details, including eligible expenses, exclusions and limitations, please refer to the [contract](#). Annual amounts, including deductibles, out-of-pocket amounts and benefit limits, are based on a Benefit Period, which runs from July 1 through June 30.

Plan Features	Blue Cross of Idaho Traditional Plan
Deductibles <ul style="list-style-type: none"> Individual Family 	<p>Insured pays first \$350 of eligible expenses per Benefit Period.</p> <p>Insureds pay a combination of \$1,050 of eligible expenses for all Insureds under same Family Coverage per Benefit Period. <i>(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)</i></p>
Out-of-Pocket Limit Deductible plus Coinsurance <ul style="list-style-type: none"> Individual Family <p>Out-of-Pocket expenses associated with the following are not included in the Out-of-pocket Limit:</p> <ul style="list-style-type: none"> Amounts that exceed the Maximum Allowance. Amounts that exceed benefit limits. Dental Covered Services, except Dental Services Related to Accidental Injury. Vision Care Covered Services. Prescription Drug Covered Services. Noncovered services or supplies. 	<p>Insured pays \$4,300 of eligible expenses per Benefit Period.</p> <p>When an Insured has met the Out-of-Pocket Limit, the benefits payable on behalf of the Insured for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services.</p> <p>Insureds pay a combination of \$8,600 of eligible expenses per Benefit Period</p> <p>When Insureds have met the Out-of-Pocket Limit, the benefits payable on behalf of all the Insureds for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services.</p> <p><i>(No Insured may contribute more than the Individual Out-of-Pocket Limit toward the Family Out-of-Pocket Limit.)</i></p>

Traditional Plan Prescription Drug Benefits		
	Participating	Non-Participating*
Tier 1: Generic Drugs Tier 2: Formulary Brand Name Drugs Tier 3: Non-Formulary Brand Name Drugs <u>Maintenance Drugs Only</u> One (1) Copayment for <i>each</i> 30-day supply Two (2) Copayments for <i>each</i> 60-day supply Three (3) Copayments for <i>each</i> 90-day supply of Maintenance drugs only (1-30 day supply, 1 Copayment; 31-60 day supply, 2 Copayments, 61-90 day supply, 3 Copayments) <u>Nonmaintenance Drugs</u> Limited to a 30-day supply at one time Note: Certain prescription drugs have Generic equivalents. If the Insured or Provider requests a Brand Name Drug and a Generic Drug is available, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug plus any applicable Copayment.	Insured pays \$10 per prescription Insured pays \$25 per prescription Insured pays \$50 per prescription	Insured pays \$10 per prescription Insured pays \$25 per prescription Insured pays \$50 per prescription * For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Insured is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment and/or Coinsurance from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.
Diabetes Management Insulin Syringes/Needles Insulin syringes/needles covered if purchased within 30 days of Insulin purchase (only 1 copayment required) Other Diabetic Supplies Benefits shall be provided for blood sugar diagnostics: <ul style="list-style-type: none"> • lancets • test strips (blood glucose and urine) • alcohol swabs 	Insulin subject to above listed pharmacy copayments. Insured pays \$10 per item	Insulin subject to above listed pharmacy copayments. Insured pays \$10 per item
Prescribed Contraceptives	BCI pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Web site, www.bcidaho.com ; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	
Human Growth Hormone Therapy (Prior Authorization required)	Subject to above listed pharmacy copayments	Subject to above listed pharmacy copayments

Traditional Plan Vision Care Benefits	
Plan Features	VSP Pays Up to the Amounts Listed
Professional Fees	Eye Exam \$50
Materials – Lenses Per Pair Single Vision, up to Bifocal, up to Trifocal, up to Lenticular, up to Frame, up to	\$50 \$80 \$95 \$125 \$50
Contact Lenses – Per Pair Elective, up to Medically Necessary, up to	\$70 \$125
Service Frequency Limitations	Insured may receive one (1) eye exam every twelve (12) months. Insured may receive one (1) pair spectacle lenses or contact lenses every twelve (12) months. Insured may receive one (1) frame every twenty-four (24) months.
Value Added Discounts from a VSP Participating Doctor	<p>The following discounts apply when visiting a VSP Participating Doctor:</p> <ul style="list-style-type: none"> • 20% savings on lens options like progressives and scratch resistant coatings when a complete pair of glasses is received. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 20% off additional pairs of glasses and non-prescription sunglasses, including non-covered lens options. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 15% off cost of contact lens exam (evaluation and fitting); materials not included. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor.

BLUE CROSS HIGH DEDUCTIBLE PLAN

The following benefits outline is an easy reference document that contains general payment information. For plan details, including eligible expenses, exclusions and limitations, please refer to the [contract](#). Annual amounts, including deductibles, out-of-pocket amounts and benefit limits, are based on a Benefit Period, which runs from July 1 through June 30.

Plan Features	High Deductible Plan
Deductibles <ul style="list-style-type: none"> Individual Family 	<p>Insured pays first \$2,000 of eligible expenses per Benefit Period.</p> <p>Insureds pay a combination of \$6,000 of eligible expenses for all Insureds under same Family Coverage per Benefit Period. <i>(No Insured may contribute more than the Individual Deductible amount toward the Family Deductible.)</i></p>
Out-of-pocket Limit Deductible plus Coinsurance <ul style="list-style-type: none"> Individual Family <p>Out-of-Pocket expenses associated with the following are not included in the Out-of-pocket Limit:</p> <ul style="list-style-type: none"> Amounts that exceed the Maximum Allowance. Amounts that exceed benefit limits. Dental Covered Services, except Dental Services Related to Accidental Injury. Vision Care Covered Services. Prescription Drug Covered Services. Noncovered services or supplies. 	<p>Insured pays \$5,000 of eligible expenses per Benefit Period</p> <p>When an Insured has met the Out-of-pocket Limit, the benefits payable on behalf of the Insured for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services.</p> <p>Insureds pay a combination of \$10,000 of eligible expenses per Benefit Period</p> <p>When Insureds have met the Out-of-pocket Limit, the benefits payable on behalf of all the Insureds for Covered Services will increase to 100% of the Maximum Allowance during the remainder of the Benefit Period, except for vision care, dental covered services, and Prescription Drug Covered Services.</p> <p>(No Insured may contribute more than the Individual Out-of-pocket Limit toward the Family Out-of-pocket Limit.)</p>

High Deductible Plan Prescription Drug Benefits		
	Participating	Non-Participating*
Tier 1: Generic Drugs Tier 2: Formulary Brand Name Tier 3: Non-Formulary Brand Name Drugs <u>Maintenance Drugs Only</u> One (1) Copayment for <i>each</i> 30-day supply Two (2) Copayments for <i>each</i> 60-day supply Three (3) Copayments for <i>each</i> 90-day supply of Maintenance drugs only (1-30 day supply, 1 Copayment; 31-60 day supply, 2 Copayments, 61-90 day supply, 3 Copayments). <u>Nonmaintenance Drugs</u> Limited to a 30-day supply at one time. Note: Certain prescription drugs have Generic equivalents. If the Insured or Provider requests a Brand Name Drug and a Generic Drug is available, the Insured is responsible for the difference between the price of the Generic Drug and the Brand Name Drug plus any applicable Copayment.	Insured pays \$10 per prescription Insured pays \$25 per prescription Insured pays \$50 per prescription	Insured pays \$10 per prescription Insured pays \$25 per prescription Insured pays \$50 per prescription *For a covered Prescription Drug dispensed by a Physician or a Licensed Pharmacist who is not a Participating Pharmacist, the Insured is responsible for paying for the Prescription Drug at the time of purchase and must submit a claim to BCI or one (1) of its designated claims processing vendors. The amount of payment for a covered Prescription Drug is the balance remaining after subtracting the Prescription Drug Copayment and/or Coinsurance from the lower of the Allowed Charge or the Usual Charge for the Prescription Drug.
Diabetes Management Insulin Syringes/Needles Insulin syringes/needles covered if purchased within 30 days of Insulin purchase (only 1 copayment required) Other Diabetic Supplies Benefits shall be provided for blood sugar diagnostics: <ul style="list-style-type: none"> • lancets • test strips (blood glucose and urine) • alcohol swabs 	Insulin subject to above listed pharmacy copayments. Insured pays \$10 per item	Insulin subject to above listed pharmacy copayments. Insured pays \$10 per item
Prescribed Contraceptives	BCI pays 100% for Women's Preventive Prescription Drugs and devices as specifically listed on the BCI Web site, www.bcidaho.com ; Deductible does not apply. The day supply allowed shall not exceed a 90-day supply at one (1) time, as applicable to the specific contraceptive drug or supply.	
Human Growth Hormone Therapy (Prior Authorization required)	Subject to above listed pharmacy copayments	Subject to above listed pharmacy copayments

High Deductible Plan Vision Care Benefits	
Plan Features	VSP Pays Up to the Amounts Listed
Professional Fees Eye Exam, up to	\$50
Materials – lenses per pair Single Vision, up to Bifocal, up to Trifocal, up to Lenticular, up to Frame, up to	\$50 \$80 \$95 \$125 \$50
Contact Lenses – per pair Elective, up to Medically Necessary, up to	\$70 \$125
Service Frequency Limitations	Insured may receive one (1) eye exam every twelve (12) months. Insured may receive one (1) pair spectacle lenses or contact lenses every twelve (12) months. Insured may receive one (1) frame every twenty-four (24) months.
Value Added Discounts from a VSP Participating Doctor	The following discounts apply when visiting a VSP Participating Doctor: <ul style="list-style-type: none"> • 20% savings on lens options like progressives and scratch resistant coatings when a complete pair of glasses is received. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 20% off additional pairs of glasses and non-prescription sunglasses, including non-covered lens options. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor. • 15% off cost of contact lens exam (evaluation and fitting); materials not included. This discount is only available within 12 months of your last eye exam given by any VSP Participating Doctor.

HOW TO FILE A CLAIM

Medical Claims

After you enroll, you will receive an identification card from Blue Cross of Idaho. Whenever you receive services from a participating or In-Network provider, just show your ID card — the provider will bill Blue Cross on your behalf.

When you use a non-participating or Out-of-Network provider, you will need to make a claim for reimbursement if the provider does not bill Blue Cross. To obtain a claim form, login to Blue Cross's [member portal](#).

Vision Benefit Claims

Blue Cross of Idaho contracts with Vision Service Plan (VSP) for administration of vision benefits. When you use a VSP contracting provider, you won't need to submit the claim - your provider will bill VSP for you. If you use a non-participating VSP provider, you will need to submit the claim yourself; to obtain a claim form, login to VSP's [member portal](#).

DENTAL PLAN

Participation in the plan is automatic for employees enrolled in one of the State's medical plans but must be elected for eligible dependents. Dental coverage is available **only** to those enrolled in one of the State's employee medical plans.

The following benefits outline is an easy reference document that contains general payment information. For plan details, including eligible expenses, exclusions and limitations, please refer to the [contract](#). Annual amounts, including deductibles, out-of-pocket amounts and benefit limits, are based on a Benefit Period, which runs from July 1 through June 30.

The Blue Cross Dental Plan pays benefits at PPO or Traditional Contracting Provider levels based on the dentist's contracting status at the time services are rendered. **To locate contracting dental plan providers, please refer to the Blue Cross of Idaho [provider directory](#).**

DENTAL CARE BENEFITS			
For Covered Providers and Services			
Benefit Limit		\$1,000 per Insured, per Benefit Period	
Orthodontic Lifetime Limit		\$1,000 per Insured	
Deductible: Individual		Insured pays \$25 per Benefit Period (Deductible does not apply to Preventive/Diagnostic Dental Covered Services received from a PPO Contracting Provider)	
	In-Network		Out-of-Network
	PPO Contracting Providers	Traditional Contracting Providers	<i>(When you choose an Out-of-Network Provider you are responsible for the difference between what BCI allows and what the Out-of-Network Provider charges)</i>
Preventive/Diagnostic Dental Services	BCI pays 80% of Maximum Allowance	BCI pays 70% of Maximum Allowance after Deductible	BCI pays 70% of Maximum Allowance after Deductible
Other Dental Services (Occlusal Guards, Sealants, Amalgam Restorations and Resin-Composite Restorations)	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 70% of Maximum Allowance after Deductible	BCI pays 70% of Maximum Allowance after Deductible
Basic Dental Services	BCI pays 80% of Maximum Allowance after Deductible	BCI pays 50% of Maximum Allowance after Deductible	BCI pays 50% of Maximum Allowance after Deductible
Major Dental Services <i>(Implants are limited to a lifetime Benefit Limit of \$900 per tooth, per Insured)</i> A twelve (12) month waiting period for Crowns, Bridges, Dentures and Dental Implants, including related services for all new Enrollees	BCI pays 50% of Maximum Allowance after Deductible	BCI pays 50% of Maximum Allowance after Deductible	BCI pays 50% of Maximum Allowance after Deductible
Orthodontic Services <i>(for eligible dependent children up to age 19 if the treatment has begun by age 17)</i> Twelve (12) month waiting period for Orthodontic Services for new Enrollees.	BCI pays 50% of Maximum Allowance	BCI pays 50% of Maximum Allowance	BCI pays 50% of Maximum Allowance

Filing Dental Claims

After you enroll, you will receive an identification card from Blue Cross of Idaho. Whenever you receive services from a participating or In-Network provider, just show your ID card — the provider will bill Blue Cross on your behalf.

When you use a non-participating or Out-of-Network provider, you will need to make a claim for reimbursement if the provider does not bill Blue Cross. To obtain a claim form, login to Blue Cross's [member portal](#).

LIFE AND DISABILITY INSURANCE

BASIC LIFE

If an employee dies while insured, the plan will pay benefits to the named beneficiary (benefits are reduced by twenty-five percent when the employee attains age seventy and an additional twenty-five percent at age 75). As follows, coverage depends on the employee's classification. Enrollment in the Basic Life plan is automatic for eligible employees; however, employees will need to designate a beneficiary. Beneficiary designation forms are available from Human Resources offices. For plan details, including eligibility, exclusions and limitations, please refer to the [contract](#).

Employee Class	Employee Basic Life Benefit	Dependent Life Benefit
Class A – Certified Officials in active status who are elected Members of Legislature	\$20,000	Spouse - \$2,000 Dependent children - \$1,000 each
Class B – Certified Officials not in Class A and all Employees in active status other than Class C employees Class C – Police officer members of the Idaho State Police as defined in Section 59-1303(3) of the Idaho Code	100% of annual salary (does not include overtime pay or bonuses). Minimum benefit: \$20,000	Spouse - \$2,000 Dependent children - \$1,000 each

To determine the benefit, annual salary (does not include overtime pay or bonuses) is rounded up to the next \$1,000 unless already a multiple of \$1,000.

Terminally ill employees may apply for an accelerated benefit. Under this benefit, they may receive up to seventy-five percent (75%) of their Basic Life benefit amount, up to \$250,000, while still living. The amount paid to beneficiaries will be reduced by the amount paid out as an accelerated benefit, plus any associated interest charges.

ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D)

The Accidental Death and Dismemberment (AD&D) benefit in the Basic Life plan is available only to eligible Class B and C employees. AD&D pays a percentage of the employee's annual salary for certain serious physical losses, including loss of life, due to a covered accident. Benefits are reduced for employees age seventy (70) or older. For plan details, including eligibility, exclusions and limitations, please refer to the [contract](#).

Covered Loss	AD&D Benefit
Loss of Life	100% of annual salary
Loss of Any of These: <ul style="list-style-type: none">• Both hands or both feet;• Both eyes;• One hand and one foot;• One hand and one eye; or• One foot and one eye.	100% of annual salary
Loss of One Hand, One Foot, or One Eye	50% of annual salary

"Loss" of a hand or foot means complete, permanent severance at or above wrist or ankle joint. Loss of an eye means the entire and irrevocable loss of sight.

VOLUNTARY TERM LIFE

This plan allows employees to purchase coverage in the amount of one, two or three times annual salary (rounded up to the next \$1,000 unless already a multiple of \$1,000) with a minimum benefit of \$20,000 and a maximum benefit of \$500,000. And when employees purchase coverage for themselves they may also purchase coverage for an eligible spouse for up to

\$50,000 (in increments of \$10,000, and not in excess of the amount they purchase for themselves) and for their children in the amount of \$10,000. Benefits are reduced by twenty-five percent when an insured attains age seventy and an additional twenty-five percent at age 75.

Terminally ill employees may apply for an accelerated benefit. Under this benefit, they may receive up to seventy-five percent (75%) of their benefit amount, up to \$250,000, while still living. The amount paid to beneficiaries will be reduced by the amount paid out as an accelerated benefit, plus any associated interest charges.

For plan details, including eligibility, exclusions and limitations, please refer to the [contract](#).

STATE POLICE OPTIONAL LIFE

This plan is available *only* to eligible **Class C employees**, police officer members of the Idaho State Police as defined in Section 59-1303(3) of the Idaho Code and provides benefits in the amount of \$50,000. For plan details, including eligibility, exclusions and limitations, please refer to the [contract](#).

FILING LIFE INSURANCE CLAIMS

Claims for life insurance benefits should be submitted as soon as possible, but no later than twelve (12) months from the date of loss. Claim forms are available by contacting the Office of Group Insurance at ogi@adm.idaho.gov or (208) 332-1860.

SHORT- AND LONG-TERM DISABILITY

Disability coverage is included in the Principal Basic Life policy, no special enrollment is required. Coverage is provided only to eligible Class B and C employees in active status. The cost of the coverage is paid by the State, so any benefits that may be paid to employees will be subject to federal and state taxes. For plan details, including eligibility, exclusions and limitations, please refer to the [contract](#).

Waiting Periods

Short-term and Long-term disability coverages contain waiting periods before benefits are payable for an approved claim. If a claim is approved, the claimant will receive detailed information about waiting periods and other plan provisions from Principal.

Plan	Waiting Period
Short-Term Disability Provides benefits of up to 60% of monthly salary.	The longer of: <ul style="list-style-type: none">• 30 continuous days of Total Disability, or;• 30 continuous days of Residual Disability, or;• The expiration of all accrued sick leave earned at the date of Disability
Long-Term Disability Provides benefits of up to 60% of monthly salary. Maximum benefit: \$4,000 per month.	The longer of: <ul style="list-style-type: none">• 26 continuous weeks of Total Disability or Residual Disability, or• The exhaustion of all sick leave earned as of the date of Total Disability or Residual Disability

Filing Disability Claims

To obtain a disability claim packet, contact the Office of Group Insurance at ogi@adm.idaho.gov or (208) 332-1860.

FLEXIBLE SPENDING ACCOUNTS

Flexible Spending Accounts (FSAs) offer a convenient and easy way to save money on eligible medical and dependent care expenses. Employees can participate in either or both accounts.

- **Medical Reimbursement Account:** Reimburses out-of-pocket health care costs not covered by any other plan.
- **Dependent Care Account:** Reimburses the cost of dependent care necessary for you and your spouse to work or attend school full-time.

Employees elect how much they want to contribute to each account when they enroll. If a qualifying event occurs, an election may be changed but participation in the plan cannot be terminated mid-year. The maximum contribution for the Medical Reimbursement account is \$2,500 per plan year and the maximum Dependent Care Account contribution is \$5,000 per plan year.

[Stanley, Hunt, DuPree and Rhine](#) (SHDR) administers the FSA; for details about the plan, please refer to the [plan document](#). When SHDR processes an enrollment form they will send the employee a packet of information including plan details, claim filing information and specifics regarding the Grace Period feature in the Dependent Care Account and the \$500 Carryover Provision in the Medical Reimbursement account.

Employees have until October 31 to file claims for any expenses incurred during the preceding plan year. Any funds remaining in an account after that filing deadline will be forfeited in accordance with IRS guidelines.